REDC
Highest Standards of Care

July 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Attention: CMS-9906-P, P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

RE: RIN 0938—AU60; CMS-9906-P
Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the REDC Consortium please accept the written comments below in response to the proposed rule "Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule" or the UPP Rule. The REDC Consortium is a national trade association of eating disorder treatment centers, representing approximately 85 percent of the higher levels of eating disorder care centers in the United States including inpatient, residential, partial hospitalization, day program, and intensive outpatient treatment. Our members agree to treatment and operational standards including accreditation by the independent accrediting bodies of the Joint Commission and/or Commission on Accreditation of Rehabilitation Facilities (CARF), conduct collaborative research, and work together to address treatment access issues facing individuals with eating disorders and their families. Most recently, the REDC Consortium launched the Standards of Excellence Project (STEP), which represents the strongest, clearest, declaration of the patient-centered values, beliefs, and principals that guide our members work every day. Our ultimate mission is to collaboratively address issues impacting treatment programs to increase access to treatment for individuals struggling with eating disorders.

REDC members are in the business of treating people affected by the serious mental illness of eating disorders and co-occurring conditions associated with the disorder, including substance use disorder. Eating disorders are complex, biologically-based serious mental illnesses that have the second highest mortality rate of any psychiatric illness—with one person losing their life every 52 minutes as a direct result of an eating disorder.[1] Approximately 28.8 million Americans experience a clinically significant eating disorder during their lifetime[2], affecting individuals of all ages, races, genders, ethnicities, socioeconomic backgrounds, body sizes, and sexual orientations.[3] Under the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: DSM-5, eating disorders include the specific disorders of anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorders.[4] These disorders are unique in that they co-occur

[1] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/
[2] Ibid.
[3] Le Grange, D., Swanson, S. A., Crow, S. J., & Merikangas, K. R. (2012). Eating disorder not otherwise specified presentation in the US population. *International Journal of Eating Disorders*, 45(5), 711-718.
[4] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: American Psychiatric Association.

and can lead to several mental health and medical complications. For example, 25 percent of people experiencing an eating disorder have a co-occurring substance use disorder.[5] Additionally, eating disorders are associated with a range of medical complications including cardiac disability, starvation, hepatitis, refeeding syndrome, cognitive dysfunction, kidney failure, esophageal cancer, osteoporosis, fractures (hip, back, etc.), hypoglycemic seizures, amenorrhea, infertility, high and low blood pressure, Type II diabetes mellitus, edema (swelling), high cholesterol levels, gall bladder disease, decalcification of teeth, severe dehydration, chronically inflamed sore throat, and inflammation and possible rupture of the esophagus.[6, 7]

When families across the nation do not have affordable and comprehensive insurance coverage that includes mental health and substance use disorder (MHSUD) treatment at all levels of care, they are not able to be admitted into specialized facilities like ours for lifesaving treatment without finding the out-of-pocket means to cover their care. Studies show that when a person with a severe eating disorder like anorexia does not receive comprehensive treatment, 41 percent of patients will relapse and are two times more likely to end up in the emergency room than someone without an eating disorder.[8] The U.S. economic impact of these eating disorder readmissions amount to $29.3 million in emergency room visits annually and $209.7 million for inpatient hospitalizations annually.[9] Barriers to comprehensive treatment cost the U.S. $64.7 billion each year with individuals and families shouldering $23.5 billion, government shouldering $17.7 billion, and employers shouldering $16.3 billion respectively.[10]

In turn, we support many of the proposals in the UPP Rule which will expand enrollment opportunities, reduce the number of uninsured persons, and restore important Affordable Care Act (ACA) programs and protections. Additionally, it is important to address how the COVID-19 pandemic has fundamentally changed how individuals and families access and how providers deliver care. The UPP Rule offers a unique opportunity to consider how care delivery models can be retained after the end of the Public Health Emergency. The following provides our support for the proposed rulemaking and considerations on how to improve ACA Marketplace plans. We look forward to working with you in the future to continue to improve access to comprehensive and affordable care for all, and welcome follow-up conversations to discuss further.

Sincerely,

Dr. Jillian Lampert, PhD, RD, LD, MPH, FAED
President, REDC Consortium

[5] Bahji, A., Mazhar, M. N., Hawken, E., Hudson, C. C., Nadkarni, P., & MacNeil, B. A. (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: a systematic review and meta-analysis. Psychiatry Research, 273, 58-66.
[6] Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical complications of anorexia nervosa and bulimia. *Am J Med*, 129(1), 30–37.
[7] Thornton, L. M., Watson, H. J., Jangmo, A., Welch, E., Wiklund, C., von Hausswolff-Juhlin, Y., . . . Bulik, C. M. (2017). Binge-eating disorder in the Swedish national registers: somatic comorbidity. *Int J Eat Disord*, 50(1), 58-65.
[8] Tackling Relapse Among Anorexia Nervosa Patients. (2013). *Eating Disorders Review*, 24, 9-11.; Yafu Zhao, M., & Encinosa, W., Ph.D. (2011, September). An Update on Hospitalizations for Eating Disorders, 1999 to 2009. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.jsp
[9] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/.
[10] Ibid.

I. Enrollment Opportunities in Health Care Marketplaces

The UPP Rule proposes several changes to improve and expand enrollment opportunities in ACA Marketplace plans. We support these changes, which include extending the open enrollment period and establishing a Special Enrollment Period (SEP) for low-income persons. According to the Congressional Budget Office, more than one-third of people who are uninsured are eligible for Medicaid or for premium tax credits (PTCs) in the ACA Marketplace.[11] These strategies will go a long way to reduce the estimated 30 million U.S. residents who are uninsured, specifically BIPOC communities that have higher rates of uninsurance than whites.[12]

Additionally, CMS is reconsidering the interpretation of **Guaranteed Availability of Coverage - § 147.104**, which would prohibit individuals from enrolling in coverage until they satisfy arrearages. **We oppose revising this provision.** The ACA is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. 300g-1). This policy would create significant hardship for individuals. For example, some consumers regularly pay their premiums but the issuers either failed to match the payment to a particular consumer's account, issue bills that do not match the amount consumers are supposed to pay, and other accounting irregularities that are of no fault to the consumers. This reconsideration appears to go against other provisions in the UPP Rule that assists in expanding opportunities for coverage. For example, CMS is proposing an **Expanded Open Enrollment - § 155.410 for the Federally Facilitated Exchanges (FFEs) to January 15. We support this change.**

As states' experience has shown, extending open enrollment greatly benefits consumers and helps reduce the number of uninsured. CMS should consider following the lead of California and New Jersey and extend open enrollment to January 31 in the FFEs and require coverage to begin February 1. Applying for health insurance and selecting a plan can be challenging and has significant impact on someone's finances and health. For many consumers, buying health insurance is one of the most complicated, and consequential, financial decisions they make, second only to buying a car or a house. Requiring people to make these important and complicated decisions in just a few weeks during the holiday season makes it more difficult to get the best coverage. Extending open enrollment to January 31 would be especially valuable for those who are auto-reenrolled into coverage but receive a lower subsidy than the prior year because the cost of their benchmark plan has dropped. For example, these enrollees may have to contribute a higher level of premium towards coverage but may be unaware given their auto-reenrollment until they receive their first bill in early January. This will allow enrollees to shop for a different plan if needed throughout the month of January.

The UPP Rule would also establish a **Special Enrollment Period for Low-Income Persons - § 155.420** who are eligible for advance premium tax credits (APTCs) and whose household income is under 150 percent of the federal poverty level. The low-income SEP would allow those eligible to enroll at any time during the year based on their income or upon learning of their eligibility. **We strongly support this proposal.**

For our patient population, the MHSUD safeguards afforded through the ACA Marketplace plans provide much better protection and coverage versus Medicare or Medicaid plans. In many, but not all cases, ACA

[11] Congressional Budget Office (September 2020). Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030. Retrieved from https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf
[12] Finegold, K., Conmy, A., Chu, R., Bosworth, A., & Sommers, B. (February 11, 2021). Issue Brief: Trends in the U.S. Uninsured Population, 2010-2020. Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf

plans must follow the Mental Health Parity and Addiction Equity Act (MHPAEA)—a critical protection as eating disorders diagnoses are consistently discriminated against in the health care system. For example, the landmark 2019 *Wit v. United Healthcare Insurance Company* case featured Natasha Wit as the main plaintiff who sought coverage for treatment of multiple chronic conditions, including severe eating disorder and was repeatedly denied treatment by UBH.[13] The 11 plaintiffs in the case represented over 50,000 patients who were denied care under UBH discriminatory policies.[14] Medicare and Medicaid plans are not subject to parity laws and do not cover all the higher levels of eating disorders treatment care, which significantly impedes early intervention whereas an ACA plan provides comprehensive coverage.

SEPs that are currently available can be so overly complex and restrictive that few of the people qualify actually use SEPs.[15] A new, year-round SEP for low-income people would reduce the number of uninsured. Some states already provide year-round enrollment to low-income people without any significant signs of adverse selection. In Massachusetts, people with incomes up to 300 percent of poverty (about $36,000 for an individual or $75,000 for a family of four) can generally enroll in marketplace coverage year-round.[16] Data from 2020 state COVID-related SEPs in Colorado and other states show that opening enrollment and reducing barriers to SEPs may actually attract younger and subsequently healthier enrollees.[17] Moreover, easing barriers to SEPs has been an important strategy to counter COVID-19. According to CMS, more than 1.5 million people signed up for coverage via HealthCare.gov between February 15 – June 30 under the COVID-19 SEP.[18] We fully expect the final data from the federal government to show that adverse selection was not a factor influencing enrollment, particularly those who qualify for $0 premium coverage.

II. Navigator Program Standards

The UPP Rule would reinstate previous **Navigator Program Standards - § 155.210** to assist consumers in certain post-enrollment activities, **which we support.** Specifically, Navigators would be required to help consumers: 1) file appeals on Exchange eligibility determinations; 2) understand basic concepts and rights associated with health coverage (such as explaining complex terms like deductible or coinsurance or helping them navigate drug formularies and provider networks); 3) apply for an exemption to maintaining minimum essential coverage from the exchange; 4) help consumers reconcile APTCs; and 5) find assistance with tax filing.

Evidence also shows that millions of people find the process of applying for and using health insurance overwhelming.[19] Many lack basic health insurance literacy. Navigators can help demystify the complexity

[13] Kennedy, Patrick & Ramstad, Jim. (2019). Landmark ruling sets precedent for parity coverage of mental health and addiction treatment. Stat News. Retrieved from https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/
[14] Ibid.
[15] Buettgens, M., Dorn, S., & Recht, H. (2015). More Than 10 Million Uninsured Could Obtain Marketplace Coverage Through Special Enrollment Periods. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf
[16] Lueck, Sarah. (June, 9, 2019). Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage. Center for Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve
[17] Connect for Health Colorado. (September 28, 2020). COVID Special Enrollment Period Observations and Lesson Learned. Retrieved from https://c4-media.s3.amazonaws.com/wp-content/uploads/2020/09/25064255/COVID-SEP-LL.pdf.
[18] Centers for Medicare & Medicaid Services. (July 14, 2021). Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline. Retrieved from https://www.cms.gov/newsroom/press-releases/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-aug-15-deadline
[19] Pollitz, K., Tolber, J., Hamel, L., & Kearney, A. (August 7, 2020). Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/

of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including BIPOC communities.[20] For individuals struggling with mental illness, having extra supports during this process can be the difference between entering treatment or forgoing treatment. Given this, it is vital that Navigators be required not only to help consumers enroll in health coverage, but also be available to assist with post-enrollment activities.

While we support the proposal to require Navigators to engage in post-enrollment activities, **we are concerned that CMS did not propose to restore the requirements to have at least two in-person Navigator organizations in each state and to ensure that at least one of those organizations was a trusted community nonprofit.** Face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and assisting with appeals. Community entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process. In-person assistance is especially critical in rural and underserved communities where people may not have reliable access to a computer or telephone. We strongly suggest CMS consider reinstating the requirements to have at least two in-person Navigator entities in every state and to ensure that at least one of those entities is a consumer-facing nonprofit.

Last, the UPP Rule would repeal a provision allowing "direct enrollment" **(Direct Enrollment - § 155.221**) exchanges, which would circumvent the ACA Marketplaces and allow insurers and web brokers to operate enrollment websites through which consumers could apply for and enroll in coverage. **We strongly support repealing this provision.**

As CMS notes, Direct Enrollment lacks key consumer protections and is contrary to the ACA's "No Wrong Door" policy. As providers treating a highly complex mental illness, our patients' inability to access treatment because of unscrupulous direct enrollment entities is a disservice to enrollees, health professionals and the intent of the ACA. Many web brokers have financial incentives to sell substandard plans, so while a few direct enrollment entities exclusively sell qualified health plans, most also sell other health products such as short-term, limited-duration insurance health plans and health care sharing ministries.[21] Commissions for short-term plans pay close to 20 percent, compared to 5 percent for an ACA-compliant plan.[22] Commissions in the ACA Marketplace have declined, and many qualified health plans pay no commission at all.[23]

As CMS knows, short-term plans provide very minimal coverage and are not required to provide Essential Health Benefits (EHBs) such as mental health and substance use disorder, hospitalization, emergency services, ambulatory services, maternity & newborn care, lab tests, pediatric services for children, rehabilitative and habilitative services, prescription drugs, and chronic disease management and preventative services. For many individuals, the limitations and exclusions within short-term plans are not

[20] Edward, J., Thompson, R., & Jaramillo, A. (June 25, 2020). Availability of Health Insurance Literacy Resources Fails to Meet Consumers Needs in Rural, Appalachian Communities: Implications for State Medicaid Waivers. *The Journal of Rural Health 37(3).* https://doi.org/10.1111/jrh.12485
[21] Straw, Tara. (March 15, 2019). "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm." Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes#_ftn13
[22] Sanger-Katz, Margot. (August 1, 2018). "What to Know Before You Buy Short-Term Health Insurance," *New York Times*. Retrieved from https://www.nytimes.com/2018/08/01/upshot/buying-short-term-health-insurance-what-to-know.html.
[23] Dickson, Virgil (April 5, 2017). "Thousands of Brokers Exit HealthCare.gov as Plan Commissions Go Unpaid," Modern Healthcare. Retrieved from https://www.modernhealthcare.com/article/20170405/news/170409972.

realized until it is too late. It is important to note that approximately 50 percent of chronic mental health conditions begin by age 14, and 75 percent begin by age 24.[24] The average delay of symptom onset and treatment intervention is 8-10 years.[25] Young individuals, attracted by lower premiums, may appear to be healthy but if they have yet to be diagnosed for an underlying MHSUD (including eating disorders), they will forgo care that is not covered by their short-term plan. Alternatively, if the individual does seek care, the out-of-pocket cost of MHSUD treatment will often shifted to medical debt owed by the young individual, their family, or back to the U.S. public healthcare system.

III. Essential Health Benefits Delivered Via Telehealth

The COVID-19 pandemic has drastically changed healthcare delivery and we commend CMS's efforts in adding numerous flexibilities in service delivery to ensure individuals can still receive the health care they need during this difficult period. The mental health impacts across the nation continue to persist with 47 percent of Americans continuing to report negative mental health impacts related to worry and stress from the pandemic.[26] According to FAIR Health, mental health conditions accounted for almost 60 percent of the top 5 diagnoses in April 2021, which is an approximate 25 percent increase from April 2020.[27, 28] Further, adolescent eating disorders diagnoses has increased by 30 percent year over year, which we have witnesses firsthand as we work on the frontlines to provide lifesaving care.[29]

To protect staff and patients and adhere to social distancing guidelines, our centers pivoted quickly to telehealth for our PHP and IOP programs. This allowed for our patients in residential care or who required PHP in-person treatment to safely continue receiving care. We estimate that 75 percent of our members are delivering care via telehealth in addition to providing in-person services. A study that came out this month compared eating disorder care in a telehealth (virtual) IOP setting vs. IOP in-person setting and found no differences in patient outcomes.[30] The findings included a significant decrease in eating disorders symptoms, depression, and perfectionism and a significant increase in body mass index/weight restoration.[31] Another study examined outcomes of providing telehealth (virtual) IOP services and reported significant and clinically meaningful improvements in all outcomes measured including self-reported eating disorders symptoms, depression and self-esteem, and overall quality of life.[32] The findings underscore what we have seen in our centers every day since the onset of the pandemic. Expanding access to eating disorders care through telehealth continues to fill a great need for individuals without transportation, individuals in

[24] National Alliance for Mental Illness. (n.d.). Mental Health Facts In America. Retrieved from https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf
[25] National Alliance for Mental Illness. (n.d.). Mental Health Screening. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Mental-Health-Screening
[26] Kearney, A., Hamel, L., & Brodie, M. (April 14, 2021). Mental Health Impact of the COVID-19 Pandemic: An Update. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/poll-finding/mental-health-impact-of-the-covid-19-pandemic/
[27] FAIR Health. Monthly Telehealth Regional Tracker, Mar. vs. Apr. 2021, United States Month-to-Month Comparison. Retrieved from https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2021-national-telehealth.pdf
[28] FAIR Health. Monthly Telehealth Regional Tracker, Apr. 2020, United States. Retrieved from https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2020-national-telehealth.pdf
[29] Tanner, Lindsay. (May 23, 2021). Pandemic has fueled eating disorder surge in teens, adults. Associated Press. Retrieved https://apnews.com/article/coronavirus-pandemic-virus-lifestyle-eating-disorders-health-27c9d5680980b1452f7e512db4d9f825
[30] Levinson, C., Spoor, S., Keshishian, A., & Pruitt, A. Pilot outcomes from a multidisciplinary telehealth versus in-person intensive outpatient program for eating disorders during versus before the Covid-19 pandemic. *Int J Eat Disord.* 2021 July 10. https://doi.org/10.1002/eat.23579.
[31] Ibid.
[32] Blalock, D., LeGrange, D., Johnson, C., Duffy, A., Manwaring, J., Tallent, C., Schneller, K., Solomon, A., Mehler, P., McClanahan, S., & Rienecke, R. Pilot assessment of a virtual intensive outpatient program for adults with eating disorders. Eur *Eat Disorders Rev.* 2020; 28:789-795. https://doi.org/10.1002/erv.2785

communities where there are no local treatment options for specialized care, individuals residing in areas with inclement weather, and for individuals with co-occurring conditions that make it feasible to participate in treatment from home whereas their condition would normally result in a no-show appointment.

Given these positive outcomes, **we urge CMS to consider integrating telehealth as a covered treatment modality for essential health benefits—especially for those seeking mental health and substance use disorders services.** Under 42 U.S. Code § 18022, the Secretary has the authority to review EHBs and modify the benefits based on changes in medical evidence or scientific advancement.

We remain increasingly concerned that payers will end telehealth coverage and remove access to medically necessary treatment for individuals. We are already starting to see this unfold as the nation's largest insurer, Optum/UnitedHealth Group has announced termination of coverage for PHP/IOP telehealth effective September 30, 2021.[33] Such coverage termination will result in the discontinuation of care for patients who are actively receiving a higher level of care and prevent patients at higher levels of treatment from transitioning to the clinically essential ambulatory levels of care.

The arbitrary end date for telehealth coverage fails to take into consideration a patients' access to treatment and there has been no effort to provide for transitional planning or continuity of care for those already in treatment. Payers have presented no clinical or public health reasoning for the discontinuation of coverage for these services; however, the federal government does have the ability to protect a patient's access to care through protecting this service delivery through the UPP Rule and we strongly urge this to be implemented.

IV. Section 1332 Waiver Guardrails

The UPP Rule would reverse attempts to undermine important guardrails governing Section 1332 waivers (**Restoration of Section 1332 Waiver Guardrails - §§ 33.108-33.132**, **155.1308, 155.1318).** The ACA's 1332 guardrails require that waivers cover at least as many people, with coverage at least as comprehensive and affordable as would be the case without the waiver, without increasing the federal deficit. **We support the proposed changes.**

With regard to **§ 155.1318**, the UPP Rule proposes to allow states to avoid adequate public notice and opportunity to comment for Section 1332 waivers in certain "emergent situations" such as natural disasters, public health emergencies, and other situations. Requirements for Section 1332 public notice and opportunity for a "meaningful level of public input" are statutory, designed to ensure public input and transparency in state efforts to transform their health delivery systems. Section 1332 waivers are designed to implement health system innovations, not to respond to disasters and other emergencies. Congress has provided other authority to respond to natural disasters and other emergencies. **We urge CMS to withdraw this proposal.**

V. Network Adequacy

The UPP Rule requests comments and input regarding **Network Adequacy - § 156.230** and how the federal government should approach network adequacy reviews. Reviews should include whether the provider network is sufficient to deliver culturally competent, anti-bias care, and with providers fully accessible to

[33] Optum Provider Express. COVID-19 IOP/PHP Telehealth Policy Updates. Retrieved from https://www.providerexpress.com/content/ope-provexpr/us/en/COVID-19_Provider_Updates/COVID-19_IOP-PHP_Telehealth_Policies.html.

persons with disabilities. One enforcement tool would be to review the number of out-of-network claims denials and assess plans with high numbers of out-of-network denials for their size. High rates of denials should prompt further review.

Further, states and CMS should conduct some direct tests or provider availability, discussed in the 2014 HHS Office of the Inspector General Report highlighting the importance of direct testing of Medicaid provider networks.[34]

VI. Conclusion

Access to quality and comprehensive care that includes MHSUD treatment is of critical importance to the work of the REDC Consortium and a key pillar for successful health outcomes for our patients and the nation. Overall, we are supportive of the bulk of the proposed changes for the 2022 plan year and urge CMS to strongly take into consideration the integration of telehealth as a delivery method for EHBs as appropriate.

We thank the agency for the opportunity to provide feedback on this important issue. However, we object to the truncated 30-day comment period. We also strongly object to tolling the comment period from the posting of the public inspection version, and not the actual Notice of Proposed Rulemaking published in the Federal Register. This practice undermines the intent and purpose of the Administrative Procedure Act and must not become the norm in rulemaking.

We look forward to reviewing the finalized rule and continuing to work together to improve access and quality healthcare to all Americans.

Sincerely,

ACUTE Center for Eating Disorders Colorado – Denver
Alsana Alabama – Birmingham
Alsana California – Monterey
Alsana California – Santa Barbara
Alsana California – Westlake Village
Alsana Missouri – St. Louis
Carolina House North Carolina – Durham
Carolina House North Carolina – Raleigh
Center for Change Idaho – Boise
Center for Change Utah – Cottonwood Heights
Center for Change Utah – Orem
Center for Discovery California – Beverly Hills
Center for Discovery California – Danville
Center for Discovery California – Del Mar
Center for Discovery California – Fremont
Center for Discovery California – Glendale
Center for Discovery California – Granite Bay
Center for Discovery California – La Habra
Center for Discovery California – La Jolla
Center for Discovery California – Lakewood
Center for Discovery California – Los Alamitos
Center for Discovery California – Menlo Park

[34] Murrin, Suzanne. (2014). State Standards For Access To Care In Medicaid Managed Care. Office of Inspector General. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

Center for Discovery California – Newport Beach
Center for Discovery California – Pleasanton
Center for Discovery California – Rancho Palos Verdes
Center for Discovery California – Sacramento
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Center for Discovery California – Torrance
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Center for Discovery Connecticut – Fairfield
Center for Discovery Connecticut – Fairfield/Wellington
Center for Discovery Connecticut – Greenwich
Center for Discovery Connecticut – Southport
Center for Discovery Florida – Maitland
Center for Discovery Florida – Monteverde
Center for Discovery Florida – North Palm Beach
Center for Discovery Florida – Tampa
Center for Discovery Georgia – Atlanta
Center for Discovery Georgia – Dunwoody
Center for Discovery Illinois – Chicago
Center for Discovery Illinois – Des Plaines
Center for Discovery Illinois – Glenview
Center for Discovery Maryland – Columbia
Center for Discovery New Jersey – Bridgewater
Center for Discovery New Jersey – Paramus
Center for Discovery New York – Hamptons
Center for Discovery Oregon – Portland
Center for Discovery Texas – Addison
Center for Discovery Texas – Austin
Center for Discovery Texas – Cypress
Center for Discovery Texas – Houston
Center for Discovery Texas – Plano
Center for Discovery Virginia – Alexandria
Center for Discovery Virginia – Fairfax
Center for Discovery Virginia – McLean
Center for Discovery Washington – Bellevue
Center for Discovery Washington – Edmonds
Center for Discovery Washington – Enumclaw
Center for Discovery Washington – Tacoma
Eating Disorders Treatment Center New Mexico – Albuquerque
Eating Recovery Center California – Sacramento
Eating Recovery Center Colorado – Denver
Eating Recovery Center Illinois – Chicago
Eating Recovery Center Illinois – Oak Brook
Eating Recovery Center Maryland – Towson
Eating Recovery Center Ohio – Cincinnati
Eating Recovery Center Texas – Austin
Eating Recovery Center Texas – Houston
Eating Recovery Center Texas – San Antonio
Eating Recovery Center Texas – Plano
Eating Recovery Center Texas – The Woodlands
Eating Recovery Center Washington – Bellevue
Eden Treatment Center Nevada – Las Vegas
Evolve Wisconsin – Appleton
Evolve Wisconsin – DePere
Evolve Wisconsin – Green Bay
Evolve Wisconsin – Oshkosh

Evolve Wisconsin – Stevens Point
Fairhaven Tennessee – Cordova
Fairwinds Florida – Clearwater
Farrington Specialty Counseling Indiana – Fort Wayne
Focus Treatment Centers Tennessee – Chattanooga
Focus Treatment Centers Tennessee –Knoxville
Gaudiani Clinic Colorado – Denver
Living Hope Eating Disorder Treatment Center Arkansas
Living Hope Eating Disorder Treatment Center Oklahoma
Magnolia Creek Alabama – Columbiana
McCallum Place Kansas – Overland Park
McCallum Place Missouri – St. Louis
Montecatini California – Carlsbad
Monte Nido California – Agora Hills
Monte Nido California – Malibu
Monte Nido Illinois – Winfield
Monte Nido Maryland – Glenwood
Monte Nido Massachusetts – Boston
Monte Nido New York – Irvington
Monte Nido New York – Long Island
Monte Nido New York – Rochester
Monte Nido Oregon – Eugene
Monte Nido Oregon – West Linn
Opal Food & Body Wisdom Washington – Seattle
Rosewood Arizona – Wickenburg
Rosewood Arizona – Tempe
Selah House Indiana – Anderson
SunCloud Illinois – Lincoln Park
SunCloud Illinois – Naperville
SunCloud Illinois – Northbrook
The Emily Program Minnesota – Duluth
The Emily Program Minnesota – Minneapolis
The Emily Program Minnesota – St. Louis Park
The Emily Program Minnesota – St. Paul
The Emily Program Ohio – Cleveland
The Emily Program Ohio – Columbus
The Emily Program Pennsylvania – Pittsburgh
The Emily Program Washington – Seattle
The Emily Program Washington – South Sound
The Emily Program Washington – Spokane
The Renfrew Center California – Los Angeles
The Renfrew Center Florida – Coconut Creek
The Renfrew Center Florida – Orlando
The Renfrew Center Florida – West Palm Beach
The Renfrew Center Georgia – Atlanta
The Renfrew Center Illinois – Chicago
The Renfrew Center Maryland – Towson
The Renfrew Center Maryland – Bethesda
The Renfrew Center Massachusetts – Boston
The Renfrew Center New Jersey – Mount Laurel
The Renfrew Center New Jersey – Paramus
The Renfrew Center New York – New York
The Renfrew Center New York – White Plains
The Renfrew Center North Carolina – Charlotte
The Renfrew Center Pennsylvania – Philadelphia
The Renfrew Center Pennsylvania – Pittsburgh
The Renfrew Center Pennsylvania – Radnor
The Renfrew Center Tennessee – Nashville

Timberline Knolls Illinois – Lemont
Timberline Knolls Illinois – Orland Park
Veritas Collaborative Georgia – Atlanta
Veritas Collaborative North Carolina – Charlotte
Veritas Collaborative North Carolina – Durham
Veritas Collaborative Virginia – Richmond
Walden Behavioral Care Connecticut – Guildford
Walden Behavioral Care Connecticut – South Windsor
Walden Behavioral Care Georgia – Alpharetta
Walden Behavioral Care Georgia – Dunwoody
Walden Behavioral Care Massachusetts – Amherst
Walden Behavioral Care Massachusetts – Braintree
Walden Behavioral Care Massachusetts – Dedham
Walden Behavioral Care Massachusetts – Peabody
Walden Behavioral Care Massachusetts – Waltham
Walden Behavioral Care Massachusetts – Westborough